Twin Valley Community Local School District

100 Education Drive
West Alexandria, Ohio 45381-1184
(937) 839-4688 Fax (937) 839-4898

Scott Cottingim
Superintendent

Tearalee Riddlebarger
Treasurer

Parents,

Students attending overnight field trips who may need medications are required to have the attached medication forms completed and signed by a Parent and Health Care Provider.

Prescription Medications
Parent and Health Care Provider must complete and sign the Request for Administration of Medication form for each prescription medication to be dispensed during the Field Trip.

Over the Counter Medications
Over the Counter Medications listed on the Field Trip Medication form will be carried by the staff. In order for your student to receive these medications on as needed basis, dispensed per the medication label this form must be completed and requires the signature of the Parent and Health Care Provider.

For other Over the Counter medications (such as meds for motion sickness, allergies, cold symptoms) the Parent and Health Care Provider must complete and sign Request for Administration of Medication form for each medication to be given.

All medications

- must be in the original container
- send only the amount of medication to be used on the trip
- must be given to the school nurse or a staff member at the time of check-in
- need to be brought by an adult and picked up by an adult

If you need to make other arrangements to bring medication to school prior to the time of departure contact the school office.

Please send completed forms to the school office at least one week prior to the trip departure.
This will allow the staff time to process, clarify and organize information and helps to streamline the check-in process on the day of departure.

Both forms must have the Parent and Health Care Provider signature. If you have your physician fax forms to the school, you are responsible for making sure that we received those forms.

If you have any questions, contact the school nurse.

Vicki Unger, RN, BSN
Twin Valley Community Local School District
100 Education Drive
West Alexandria, Ohio 45381
Elementary 937-839-4315 Middle School 937-839-4165 High School 937-839-4693
vunger@tvs.k12.oh.us

Please return medication forms to school one week prior to departure of trip.

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(937) 839-4688 FAX (937) 839-4898
- An Equal Opportunity Employer -

Field Trip Medications
- Field Trip Only -

School: TVS ☐ Elementary ☐ Middle School ☐ High School

Student: _____ _____ _____ **Birth Date:** _____
Last *First* *Middle*

Address: _____ _____
Telephone

Allergies: _____

Please indicate with a check which medication(s) your child may receive and the symptoms for which the selected medications may be used.

☐ **Acetaminophen** (Tylenol): tablets, will be administered according to label instructions. Please check the symptoms below for which your child may receive this medication.

☐ For headache ☐ For Fever Greater than 100 ☐ For menstrual cramps
☐ Other, please list _____

☐ **Ibuprofen** (Advil, Motrin): tablets, will be administered according to label instructions. Please check the symptoms below for which your child may receive this medication.

☐ For headache ☐ For Fever Greater than 100 ☐ For menstrual cramps
☐ Other, please list _____

☐ **Antacids** (Tums, Rolaids): chewable tablets, will be administered according to label instructions. Please check the symptoms below for which your child may receive this medication.

☐ Upset stomach
☐ Other, please list _____

☐ **Anti-Itch Lotion** (Calamine): lotion, will be administered according to label instructions. Please check the symptoms below for which your child may receive this medication.

☐ For pain, itching, discomfort from minor skin irritations
☐ Other, please list _____

☐ **Antibiotic Ointment** (Bacitracin Ointment): ointment, will be administered according to label instructions. Please check the symptoms below for which your child may receive this medication.

☐ To help prevent infection in minor cuts, scrapes, burns
☐ Other, please list _____

YES, I want my child to receive medications listed above as needed – Parent and Physician Signature Required

Signature of Parent: _____ Date: _____

Signature of Physician: _____ Date: _____

NO, I do not want my child to receive medications - Parent Signature is Required

No, I do not want my child to receive any of the above medications while on the field trip. I understand that without a doctor's signature on the form above, TVS staff will not be able to give my child any medications.

Signature of Parent: _____ Date: _____

Please complete and return form to school by: ***One week prior to trip departure.***

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Request for Administering Medication
- Field Trip Only –

One Medication per Form

School: TVS ☐ Elementary ☐ Middle School ☐ High School

Student: _____ _____ _____ **Date of Birth:** _____
Last *First* *Middle*

Address: _____ _____ _____ _____ _____
Number Street Name *Town* *State* *Zip + 4* *Telephone*

Part I. Medication (one per form) to be Taken on the Field Trip – To be Completed by Physician

The above mentioned student is under my care for (Diagnosis): _____

and should receive: _____ _____
Name of Drug *Dosage and Route*

At the following times: _____

Administration to begin: _____ Administration to end: _____

Severe adverse reaction to be reported to the physician: _____

_____

Special Instructions: _____

_____

Inhalers

Is student authorized to self-medicate? ☐ Yes ☐ No

Inhaler to be: ☐ Carried by student at all times ☐ Kept in a central location

Epi-Pen

Is student authorized to self-medicate? ☐ Yes ☐ No

Epi-pen to be: ☐ Carried by student at all times ☐ Kept in a central location

Significant side effects: _____

Duration of treatment: _____

Other information: _____

Part II: To be Completed by Physician.

Name(s) of Physician: _____

Address of Physician _____

Telephone Number: _____ Emergency Number: _____

Signature of Physician: _____ Date: _____

Part III: To be Completed by Parent or Guardian and Returned to School.

I request that the above described medication be administered to my child according to the instructions provided. I agree to deliver the medicine to the school in the container in which it was dispensed by the prescribing physician or licensed pharmacist. I grant permission for the school nurse to confer with the above licensed prescriber regarding my child's health and treatment issues as they pertain to the above medication/diagnosis and his/her educational and behavioral management needs. If the above information changes, I will submit a revised statement signed by the physician.

Signature of Parent: _____ **Date:** _____

Address: _____ _____ _____ _____ _____
Number Street Name *Town* *State* *Zip + 4* *Telephone*

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Request for Administering Medication
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One Medication per Form

Student: ______________________ ______________________ ______________________
Last *First* *Middle*

Medication: ______________________________ **Start:** ____________ **Stop:** ____________

Special Instructions: ____

Date	Time	Initials	Date	Time	Initials	Date	Time	Initials

Accept		
	AB – Absent	SD – School Delay
	ED – Early Dismissal	NS – No School
	FT – Field Trip	NMS – No Medication at School

Varianc		
	VO – Omitted Dose	VW – Wrong Child
	VD – Wrong Dose/Amount	VM – Wrong Medication
	VT – Wrong Time	VS – Student Refused

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Table Codes	
	DC – Discontinue Medication

Table Codes	